

# Registered pharmacy inspection report

**Pharmacy Name:** Well, 24 Glasgow Road, PAISLEY, Renfrewshire, PA1  
3QH

**Pharmacy reference:** 1042924

**Type of pharmacy:** Community

**Date of inspection:** 23/03/2023

## Pharmacy context

This is a community pharmacy in Glasgow. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy provides substance misuse services and dispenses private prescriptions. Pharmacy team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via 'patient group directions' (PGDs).

## Overall inspection outcome

✓ **Standards met**

**Required Action:** None

Follow this link to [find out what the inspections possible outcomes mean](#)

## Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

Pharmacy team members follow good working practices. And they manage dispensing risks to keep services safe. Pharmacy team members recognise and appropriately respond to safeguarding concerns. They suitably protect people's private information and keep the records they need to by law. Team members make records of mistakes and review the pharmacy's processes and procedures. They learn from mistakes and take the opportunity to improve the safety of services.

### Inspector's evidence

The pharmacy had control measures in place to manage the risks and help prevent the spread of infections. This included a plastic screen at the medicines counter which faced onto the waiting area. The company used 'standard operating procedures' (SOPs) to define the pharmacy's working practices. And it issued new and updated procedures via its online operating system. Relevant SOPs were available in each team member's online file for them to read and follow. And the company notified them when it issued new or updated versions. Once read, they annotated the relevant record to show they understood them. This was reflected in their training record. A sample of SOPs showed they were up to date. This included the 'responsible pharmacist' and controlled drug' SOPs that had been reviewed in May 2021. A sample of training records showed a dispenser had read the SOPs that were relevant to their role. One of the dispensers was undergoing an accuracy in dispensing course. And the pharmacist was planning on arranging a SOP that defined the checking procedure for the relevant team members to follow.

Team members signed medicine labels to show who had 'dispensed' and who had 'checked' prescriptions. This meant the pharmacist was able to help individuals learn from their dispensing mistakes. The pharmacist was arranging a signature audit trail prescription stamp to show clinical and accuracy checks. This helped accuracy checkers identify prescriptions they were authorised to check. The pharmacist kept hard copies of near miss errors. And they transferred them onto the company's online form when they had time. This helped them to carry out near-miss reviews at the end of the month. The pharmacist had recorded a significant number of near miss errors for February 2023. But they had been unable to carry out a documented review at the end of the month due to time constraints and annual leave. The online system produced an info graphic to show any patterns and trends for them to consider. The pharmacist knew that 'incorrect quantity' accounted for most of the near misses in February 2023. And they discussed the findings with the rest of the team who agreed to take extra care and highlight part-packs before placing them on the dispensary shelves. Team members made use of a 'similar name CHECK!' caution label. And it had been used to highlight 'look alike and sound alike' (LASAs) medicines including aspirin 75mg and 300mg tablets.

The pharmacy provided information about its complaints process on a notice in the waiting area. And it encouraged people to provide feedback about the services they received. Team members had discussed some of the feedback, and they had reviewed their prescription waiting times to manage people's expectations. Team members knew to record dispensing incidents on an electronic form which they sent to the superintendent's office to review. The form included a section to record information about the root cause and any mitigations to improve safety arrangements. The company carried out regular internal audits against professional standards to highlight areas for improvement and to ensure

the pharmacy was operating safely. And a routine audit was due in the next few days. This helped to provide assurance that the pharmacy was operating safely and effectively and to highlight any areas for improvement.

Team members maintained the records they needed to by law. And the pharmacy had public liability and professional indemnity insurances in place. The pharmacist displayed a 'responsible pharmacist' RP notice which was visible from the waiting area. And the RP record showed the name and registration details of the pharmacist in charge. Team members maintained the electronic 'controlled drug' (CD) registers and kept them up to date. And they showed they checked the balance at least twice a month. People returned CDs they no longer needed for safe disposal. And the pharmacy had an electronic CD destruction register to record all the items it received for safe disposal. The pharmacy filed prescriptions so they could be easily retrieved if needed. And records of supplies against private prescriptions and supplies of 'specials' that were up to date. The pharmacy provided training so that team members understood data protection requirements and how to protect people's privacy. And they used a designated container to dispose of confidential waste. An approved provider collected the waste for off-site destruction. The pharmacy trained its team members to manage safeguarding concerns. And it provided a protocol for them to refer to. This included contact details for local agencies. Team members knew to speak to the pharmacist whenever they had cause for concern. And they communicated with relevant agencies to discuss concerns about vulnerable people. A chaperone notice at the entrance to the consultation room advised that people could be accompanied during consultations.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

Pharmacy team members have the necessary qualifications and skills for their roles and the services they provide. And they work together well to manage the workload. Pharmacy team members continue to learn to keep their knowledge and skills up to date. And the pharmacy supports new team members to learn during their induction.

### Inspector's evidence

The pharmacy's prescription workload had remained stable over the past year. It had capped the number of multi-compartment compliance packs it dispensed due to team members undergoing training. And the pharmacist had agreed to register new people once the team members had completed their courses. The pharmacist had been in post since October 2022 and the other team members were well-established in their roles. Regular locum pharmacists and relief dispensers provided cover when necessary and a relief dispenser was providing annual leave cover at the time of the inspection. The following staff were in post; one full-time pharmacist, one full-time trainee pharmacy technician, one full-time dispenser, one part-time dispenser, one part-time trainee dispenser and one delivery driver.

The pharmacist supported new team members to learn and develop. And a new trainee dispenser had completed the company's mandatory induction process. This included completing health and safety training. It also included reading the pharmacy's policies and procedures. The pharmacist supported team members in their learning and development activities. And they allocated protected learning time to support those undergoing qualification training. For example, they provided a trainee pharmacy technician with a half day each week which they used for home study. The company provided access to ongoing training for team members to complete. And they logged on to the company's online system to access the learning. The pharmacist had been prioritising the trainee's qualification training, and once completed the regular ongoing training activities would recommence. The pharmacy provided a seasonal flu vaccination service. And the pharmacist had completed the necessary training to be eligible to provide the service.

The pharmacist kept the pharmacy team up to date with new initiatives and procedural changes. They discussed progress against performance standards and targets which was illustrated on a large tracker on the dispensary wall. This included registering people with the services the pharmacy was offering, such as a text service to notify people about their prescriptions and when they were ready for collection. Team members had successfully identified prescriptions that could be sent to the company's offsite hub for dispensing to increase the pharmacy's workload capacity. Team members discussed the findings from the monthly near miss review to discuss safety improvements. This included LASA medications to manage the risk of selection errors. Pharmacy team members were proactive at making changes and improvements with the pharmacist's approval. And the trainee pharmacy technician had recently re-organised the serial prescriptions file for better access.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy's premises support the safe delivery of its services. And it effectively manages the space for the storage of its medicines. The pharmacy has suitable arrangements for people to have private conversations with the team.

### Inspector's evidence

This was a modern, purpose-built pharmacy in large premises with ample storage and dispensing benches. A sound-proofed consultation room provided a confidential environment for private consultations. The room was clearly marked, and team members used a keypad code to prevent unauthorised access. It had a sink with hot and cold running water, and it provided a clinical environment for the delivery of professional services.

The dispensary had a sink with hot and cold running water. And team members used it for hand washing and the preparation of medicines. They cleaned and sanitised the pharmacy daily, and this ensured it remained hygienic for its services. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment from which to provide services. A separate room provided adequate space for team members to take breaks.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy provides services which are easily accessible. And it manages its services well to help people receive appropriate care. The pharmacy gets its medicines from reputable sources, and it stores them appropriately. The team conducts checks to make sure medicines are in good condition and suitable to supply. And it has arrangements to identify and remove medicines that are no longer fit for purpose.

### Inspector's evidence

The pharmacy had a step-free entrance and a pressure operated door. This helped people with mobility difficulties access services. The pharmacy displayed information in the window. This included its opening hours and information relating to the most recent community pharmacy public health campaign. The pharmacist provided access to 'prescription only medicines' (POM) treatments against 'patient group directions' (PGDs). And the PGD for treatments for urinary tract infections was valid until August 2024. The pharmacy purchased medicines and medical devices from recognised suppliers. And team members conducted monitoring activities to confirm that medicines were safe to supply. This included date checking activities and attaching 'use this pack first' stickers to highlight short-dated medicines. A date checking matrix was on the dispensary wall and visible to pharmacy team members. This helped them to keep track of when checks were next due. The pharmacy used two fridges to keep medicines at the manufacturers recommended temperature. Team members used one to keep most of the stock. And they used another one for vaccinations and items awaiting collection which they had placed in clear bags for improved visibility. Team members monitored and recorded the temperatures every day. And this provided assurance that the fridge was operating within the accepted range of two and eight degrees Celsius. Team members kept stock neat and tidy on a series of shelves. And they used secure controlled drug cabinets for some items and medicines were well-organised. The pharmacy had medical waste bins and 'controlled drug' (CD) denaturing kits available to support the team in managing pharmaceutical waste.

Team members prioritised drug alerts and they knew to check for affected stock so that it could be removed and quarantined straight away. Records showed a recent drug alert for pholcodine medication which they had removed from stock. Team members followed the company's procedure which included updating the relevant online form to inform the superintendent's office they had taken the necessary actions. Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew about the warning labels on the valproate packs, and they knew to apply dispensing labels so as not to cover-up the warning messages. The pharmacy supplied patient information leaflets and patient cards with every supply. Team members used dispensing baskets to safely hold medicines and prescriptions during dispensing. And this helped to manage the risk of items becoming mixed-up. The pharmacy supplied medicines in multi-compartment compliance packs to help people with their medication. And the company had defined the assembly and dispensing process in a documented procedure for team members to refer to. The pharmacist had capped the service. This was due to the extra resources needed to support team members undertaking qualification training. But, the pharmacy continued to register people if they were in urgent need of extra support with their medicines. Trackers helped team members plan and dispense. And supplementary records provided a list of each person's current

medication and dose times which they kept up to date. They checked new prescriptions against the records for accuracy. Team members provided descriptions of medicines on the dispensing labels. And they supplied patient information leaflets for people to refer to. Packs were placed in clear bags for improved visibility and stored in boxes in alphabetical order on a series of shelves until they were supplied in paper prescription bags. Team members were proactive at managing the risks in the pharmacy. And they had separated storage boxes which were labelled with the same surname to manage the risk of hand out errors. They also dispensed these packs on different weeks of the four-week dispensing cycle to manage the risk of mix ups. People collected the packs either themselves or by a representative. And the team members monitored the collections to confirm they had been collected on time. The delivery driver followed a schedule to track deliveries and they highlighted failed deliveries. Team members contacted family members or other relevant authorities to raise concerns and ensure that people were receiving support when necessary.

The pharmacy supervised the consumption of some medicines. And team members dispensed some doses using an automated dispensing machine. They obtained a clinical and accuracy check at the time of registering new prescriptions on the system. And the pharmacist carried out a final accuracy check at the time they made the supply. The pharmacy dispensed serial prescriptions for a considerable number of people that had registered with the 'medicines: care and review' service (MCR). The pharmacy had a system for managing dispensing. And they retrieved prescriptions a week before they were due so they could order items in advance. Most people collected their medication when it was due. And team members knew to refer people who arrived either too early or too late so the pharmacist could check compliance. The pharmacy used an offsite hub for dispensing most of the prescriptions it received. The pharmacist checked the prescriptions to make sure they were clinically appropriate. And they also checked that the prescription information had been inputted accurately before sending it to the hub for dispensing. Once assembled, the hub placed the medications into sealed prescription bags and into separate totes for delivery to the pharmacy. The pharmacist checked a random sample of prescriptions as per the company's procedure for accuracy. This provided assurance that the hub's dispensing system was safe and effective.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its facilities to suitably protect people's confidential information.

### Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures for substance misuse medicines. They had highlighted the measures, so they were used exclusively for this purpose. The pharmacy used an automated dispensing system to dispense methadone doses. The dispenser calibrated the system each morning to ensure accuracy of doses. The pharmacy kept a blood pressure monitor, and a February 2024 label showed that a calibration was up to date. This meant the pharmacy could provide assurance that the monitors were measuring accurately. The pharmacy stored prescriptions for collection out of view of the public waiting area. And it positioned the dispensary computers in such a way as to prevent disclosure of confidential information. Team members could conduct conversations in private if needed, using portable telephone handsets. The pharmacy used cleaning materials for hard surface and equipment cleaning. And the sink was clean and suitable for dispensing purposes.

### What do the summary findings for each principle mean?

Finding	Meaning
✓ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✓ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✓ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.